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RURAL PRIMARY HEALTH CARE

Agreement Between the
UNITED STATES OF AMERICA
and THAILAND

Signed at Bangkok May 4, 1979

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THAILAND

Rural Primary Health Care

Agreement signed at Bangkok May 4, 1978;
Entered into force May 4, 1978.

A.I.D. Project No. 493-0291

A.I.D. Loan No. 493-T-021

PROJECT

LOAN AGREEMENT

Between the

KINGDOM OF THAILAND

and the

UNITED STATES OF AMERICA

for

RURAL PRIMARY HEALTH CARE

Dated: May 4, 1978

TIAS 9422

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[1] Not printed herein. The annex is deposited in the archives of the Department of State where it is available for reference. [Footnote added by the Department of State.]

A.I.D. Project No. 493-0291

A.I.D. Loan No. 493-T-021

PROJECT LOAN AGREEMENT

Dated: May 4, 1978

Between the Kingdom of Thailand (Borrower), acting through the Ministry of Finance (MOF), and the United States of America, acting through the United States Agency for International Development (U.S.A.I.D.)/Thailand of the Agency for International Development ("A.I.D.").

Article 1: The Agreement

The purpose of this Agreement is to set out the understandings of the parties named above ("Parties") with respect to the undertaking by the Borrower of the Project described herein, and with respect to the financing of the Project by the Parties.

Article 2: The Project

SECTION 2.1 Definition of Project. The Project, which is further described in Annex 1, is to make primary health

care services more readily available to the rural poor in Thailand, with primary focus on twenty specific provinces, through an expanded rural primary health care delivery system with strengthened and innovative training, management, evaluation and research practices.

Within the limits of the definition of the Project in this Section 2.1, elements of the amplified description stated in Annex 1 may be changed by written agreement of the authorized representatives of the Parties named in Section 9.2 without formal amendment of this Agreement.

Article 3: Financing

SECTION 3.1 The Loan. To assist the Borrower to meet the costs of carrying out the Project, A.I.D., pursuant to the Foreign Assistance Act of 1961, as amended,[1] agrees to lend the Borrower under the terms of this Agreement not to exceed Five Million Five Hundred Thousand United States ("U.S.") dollars ($5,500,000) ("Loan"). The aggregate amount of disbursements under the Loan is referred to as "Principal." The Loan may be used to finance foreign exchange costs, as defined in Section 7.1, and local currency costs, as defined in Section 7.2, of goods and services required for the Project.

[1] 75 Stat. 424; 22 U.S.C. § 2151 note. [Footnote added by the Department of State.]

SECTION 3.2 Borrower Resources for the Project.

(a) The Borrower agrees to provide or cause to be provided for the Project all funds, in addition to the Loan, and all other resources required to carry out the Project effectively and in a timely manner.

(b) The resources provided by the Borrower for the Project, including costs borne on an "in-kind" basis will not be less than the equivalent of Five Million Two Hundred Thirty Thousand United States Dollars ($5,230,000).

SECTION 3.3 Project Assistance Completion Date.

(a) The Project Assistance Completion Date (PACD), which is May 3, 1982, or such other date as the Parties agree to in writing, is the date by which the Parties estimate that all services financed under the Loan will have been performed and all goods financed under the Loan will have been furnished for the Project as contemplated in this Agreement.

(b) Except as A.I.D. may otherwise agree in writing, A.I.D. will not issue or approve documentation which would authorize disbursement of the Loan for services performed subsequent to the PACD or for goods furnished for the Project, as contemplated in this Agreement, subsequent to the PACD.

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(c) Requests for disbursement, accompanied by necessary supporting documentation prescribed in Project Implementation Letters, are to be received by A.I.D. or any bank described in Section 8.1 no later than nine (9) months following the PACD, or such other period as A.I.D. agrees to in writing. After such period, A.I.D. giving notice in writing to the Borrower, may at any time or times reduce the amount of the Loan by all or any part thereof for which requests for disbursement, accompanied by necessary supporting documentation prescribed in Project Implementation Letters, were not received before the expiration of said period.

Article 4: Loan Terms

SECTION 4.1. Interest. The Borrower will pay to A.I.D. interest which will accrue at the rate of two percent (2%) per annum for ten years following the date of the first disbursement hereunder and at the rate of three percent (3%) per annum thereafter on the outstanding balance of Principal and on any due and unpaid interest. Interest on the outstanding balance will accrue from the date (as defined in Section 8.5) of each respective disbursement, and will be payable semi-annually. The first payment of interest will be due and payable no later than six (6) months after the first disbursement hereunder, on a date to be specified by A.I.D.

SECTION 4.2. Repayment. The Borrower will repay to A.I.D. the Principal within thirty (30) years from the date of the first disbursement of the Loan in forty-one (41) approximately equal semi-annual installments of Principal and interest. The first installment of Principal will be payable nine and one-half (9½) years after the date on which the first interest payment is due in accordance with Section 4.1. A.I.D. will provide the Borrower with an amortization schedule in accordance with this Section after the final disbursement of the Loan.

SECTION 4.3. Application, Currency, and Place of Payment. All payments of interest and Principal hereunder will be made in U.S. Dollars and will be applied first to the payment of interest due and then to the repayment of Principal. Except as A.I.D. may otherwise specify in writing, payments will be made to the Controller, Office of Financial Management, Agency for International Development, Washington, D.C. 20523, U.S.A., and will be deemed made when received by the Office of Financial Management.

SECTION 4.4. Prepayment. Upon payment of all interest and any refunds then due, the Borrower may prepay, without penalty, all or any part of the Principal. Unless A.I.D. otherwise agrees in writing, any such prepayment will be applied to the installments of Principal in the inverse order of their maturity

SECTION 4.5. Renegotiation of Terms.

(a) The Borrower and A.I.D. agree to negotiate, at such time or times as either may request, an acceleration of the repayment of the Loan in the event that there is any significant and continuing improvement in the internal and external economic and financial position and prospects of Thailand which enables the Borrower to repay the Loan on a shorter schedule.

(b) Any request by either Party to the other to so negotiate will be made pursuant to Section 9.1, and will give the name and address of the person or persons who will represent the requesting Party in such negotiations.

(c) Within thirty (30) days after delivery of a request to negotiate, the requested Party will communicate to the other, pursuant to Section 9.2, the name and address of the person or persons who will represent the requested Party in such negotiations.

(d) The representatives of the Parties will meet to carry on negotiations no later than thirty (30) days after delivery of the requested Party's communication under subsection (c). The negotiations will take place at a location mutually agreed upon by the representatives of the Parties, provided that, in the absence of mutual agreement, the negotiations will take place in Thailand at the Borrower's Ministry of Finance.

SECTION 4.6. Termination on Full Payment. Upon payment in full of the Principal and any accrued interest, this Agreement and all obligations of the Borrower and A.I.D. under it will cease.

Article 5: Conditions Precedent to Disbursement

SECTION 5.1. First Disbursement. Prior to the first disbursement under the Loan, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Borrower will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(a) An opinion of counsel acceptable to A.I.D. that this Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Borrower, and that it constitutes a valid and legally binding obligation of the Borrower in accordance with all of its terms;

(b) A statement of the names of the persons designated pursuant to Section 9.2 as additional representatives of the Borrower, together with a specimen signature of each such person and a statement of the extent of his or her authority; and

(c) Assurances that the technical assistance staff to be funded under the Loan who will be working in the Health

Planning Division of the Ministry of Public Health will be provided with adequate office space, equipment, and transportation facilities to perform their assigned tasks effectively.

(d) Assurances that the research and evaluation specialist and the research assistant of the A.I.D.-funded technical assistance staff will be provided with counterparts from the Borrower who are professionals with appropriate backgrounds and comparable skills.

SECTION 5.2. Additional Disbursement. Prior to disbursement under the Loan or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made for training costs, the Borrower will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(a) A detailed master training plan setting forth the purpose and scope, a time schedule and curricula for the proposed training and a staffing pattern for trainers.

(b) For trainees other than village health volunteers, village health communicators and child nutrition center attendants, evidence that at the time training for such trainees is to commence, the Borrower has established and made appropriate budgetary allocations on a permanent basis for positions to be staffed by each group of trainees whose training costs are to be financed under the Loan.

SECTION 5.3. Notification. When A.I.D. has determined that the conditions precedent specified in Section 5.1 and 5.2 have been met, it will promptly notify the Borrower.

SECTION 5.4. Terminal Dates for Conditions Precedent. If all of the conditions specified in Section 5.1 have not been met within ninety (90) days from the date of this Agreement, or if the condition specified in Section 5.2(a) has not been met within one hundred and twenty (120) days from the date of this Agreement, or such later date or dates, as A.I.D. may agree in writing, A.I.D., at its option, may cancel the then undisbursed balance of the Loan, to the extent not irrevocably committed to third parties, and may terminate this Agreement by written notice to the Borrower. In the event of such termination, the Borrower will repay immediately the Principal then outstanding and any accrued interest; on receipt of such payments in full, this Agreement and all obligations of the Parties hereunder will terminate.

Article 6: Special Covenants

SECTION 6.1. Project Evaluation. The Parties agree to establish an evaluation program as an integral part of the Project. Except as the Parties otherwise agree in writing,

the program will include, during the implementation of the Project and at one or more points thereafter, (a) evaluation of progress toward attainment of the objectives of the Project, (b) identification and evaluation of problem areas or constraints which may inhibit such attainment, (c) assessment of how such information may be used to help overcome such problems, in this or other projects, and (d) evaluation, to the degree feasible, of the overall development impact of the Project. Joint evaluations will be conducted by the Borrower and A.I.D. in accordance with the plan set forth as Attachment I-B to Annex I of the Agreement.

SECTION 6.2. Supervision. The Borrower covenants that adequate supervision will be given to all health professionals in the Project, particularly including auxiliary midwives, village health volunteers and village health communicators.

SECTION 6.3. Logistics and Supply System. The Borrower covenants that the existing health logistics and supply system will be expanded at a pace commensurate with the development of health facilities and the assignment of health personnel to the rural areas under the Project.

SECTION 6.4. Planning, Management and Information System. The Borrower covenants that the planning, management and information system being developed and implemented by the Ministry of Public Health in cooperation with the World

Health Organization will be expanded systematically at all levels in the Project's selected provinces as health personnel are trained and posted to those provinces.

SECTION 6.5. Technical Advisory Services. The Parties agree that a contract or contracts will be entered into on a timely basis with individuals or organizations to provide technical advisory services for Borrower's health planning and research program under the Project.

Article 7: Procurement Source

SECTION 7.1. Foreign Exchange Costs. Disbursements pursuant to Section 8.1 will be used exclusively to finance the costs of goods and services required for the Project having their source and origin in countries included in Code 941 of the A.I.D. Geographic Code Book as in effect at the time orders are placed or contracts entered into for such goods and services ("Foreign Exchange Costs"), except as A.I.D. may otherwise agree in writing, and except as provided in the Project Loan Standard Provisions Annex, Section C.1(b) with respect to marine insurance.

SECTION 7.2. Local Currency Costs. Disbursements pursuant to Section 8.2 will be used exclusively to finance the costs of goods and services required for the Project

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having their source and, except as A.I.D. may otherwise agree in writing, their origin in Thailand ("Local Currency Costs").

Article 8: Disbursements

SECTION 8.1 Disbursement for Foreign Exchange Costs.

(a) After the satisfaction of conditions precedent, the Borrower may obtain disbursements of funds under the Loan for the Foreign Exchange Costs of equipment and advisory services required for the Project in accordance with the terms of this Agreement, by such of the following methods as may be mutually agreed upon:

(1) by requesting A.I.D. to issue Letters of Commitment or other assurance directly to one or more contractors or suppliers, committing A.I.D. to pay such contractors or suppliers for such goods or services.

(2) by requesting A.I.D. to issue Letters of Commitment for specified amounts to one or more U.S. banks, satisfactory to A.I.D., committing A.I.D. to reimburse such bank or banks for payments made by them to contractors or suppliers, under Letters of Credit or otherwise, for such goods or services.

(b) Banking charges incurred by Borrower in connection with Letters of Commitment and Letters of Credit will be

financed under the Loan unless the Borrower instructs A.I.D. to the contrary. Such other charges as the Parties may agree to may also be financed under the Loan.

SECTION 8.2. Disbursement for Local Currency Costs

(a) After satisfaction of conditions precedent, the Borrower may obtain disbursements of funds under the Loan for Local Currency Costs required for the Project in accordance with the terms of this Agreement, by submitting to A.I.D., with necessary supporting documentation as described in Project Implementation Letters, requests to finance such costs.

(b) The local currency needed for such disbursement hereunder may be obtained by acquisition by A.I.D. with U.S. dollars by purchase.

The U.S. dollar equivalent of the local currency made available hereunder will be the amount of U.S. dollars required by A.I.D. to obtain the local currency.

SECTION 8.3. Other Forms of Disbursement. Disbursements of the Loan may also be made through such other means as the Parties may agree to in writing.

SECTION 8.4 Rate of Exchange. If funds provided under the Loan are introduced into Thailand by A.I.D. or any public or private agency for purposes of carrying out obligations of A.I.D. hereunder, the Borrower will make such arrangements as may be necessary so that such funds

may be converted into currency of Thailand at the highest rate of exchange which, at the time the conversion is made, is not unlawful in Thailand.

SECTION 8.5. Date of Disbursement. Disbursements by A.I.D. will be deemed to occur (a) on the date on which A.I.D. makes a disbursement to the Borrower or its designee, or to a bank, contractor or supplier pursuant to a Letter of Commitment, contract, or purchase order; or (b) on the date on which A.I.D. disburses to the Borrower or its designee local currency acquired in accordance with Section 8.2.

Article 9: Miscellaneous

SECTION 9.1. Communications. Any notice, request, document or other communication submitted by either Party to the other under this Agreement will be in writing or by telegram or cable, and will be deemed duly given or sent when delivered to such party at the following address:

To the Borrower:

Mail Address: Ministry of Finance
Royal Grand Palace
Bangkok, Thailand

Cable Address: Minance
Bangkok, Thailand

To A.I.D.:

Mail Address: United States Agency for
International Development
American Embassy
Bangkok, Thailand

Cable Address: USAID
Bangkok, Thailand

All such communications will be in English, unless the Parties otherwise agree in writing. Other addresses may be substituted for the above upon the giving of notice.

SECTION 9.2. Representatives. For all purposes relevant to this Agreement, the Borrower will be represented by the individual holding or acting in the Office of Minister of Finance and A.I.D. will be represented by the individual holding or acting in the Office of Director, United States Agency for International Development, each of whom, by written notice, may designate additional representatives for all purposes other than exercising the power under Article 2 to revise elements of the amplified description in Annex 1. The names of the individuals designated as additional representatives of the Borrower, with specimen signatures,

will be provided to A.I.D., which may accept as duly authorized any instrument signed by such representatives in implementation of this Agreement, until receipt of written notice of revocation of their authority.

SECTION 9.3. Standard Provisions Annex. A "Project Loan Standard Provisions Annex" (Annex II)[1] is attached to and forms part of this Agreement.

IN WITNESS WHEREOF, the Kingdom of Thailand and the United States of America, each acting through its duly authorized representative, have caused this Agreement to be signed in their names and delivered as of the day and year first above written.

KINGDOM OF THAILAND

BY: Suphat Sutatum
Minister of Finance

UNITED STATES OF AMERICA

BY: Charles S. Whitehouse
Ambassador

[1] See footnote 1, p. 4 [Footnote added by the Department of State.]

ANNEX 1

RURAL PRIMARY HEALTH CARE PROJECT

Detailed Project Description

1. Introduction

As indicated in Article 2, the project purpose is to expand and improve the rural health delivery system of the Royal Thai Government Ministry of Public Health (RTG MOPH) in 20 provinces of Thailand through:

- innovative training,
- strengthened research and evaluation capabilities, and
- more efficient management practices.

The project described here will directly relate to the Accelerated Family Planning and Health project currently being planned by the RTG to construct new, and improve existing, health facilities in 20 rural provinces of Thailand. These provinces have been selected because they have relatively large populations and poor health coverage. (See next page describing provinces).

The project described herein will strengthen the RTG/AFPH project appreciably by improving the existing rural health care system, specifically the manpower capability at district hospitals, second class health centers, midwifery centers and remote villages in these provinces in addition to improving supervisory and management skills.

This section will provide a detailed description of the proposed training, and evaluation-research components. Each of these project elements will be considered in terms of needs, expected outputs and required inputs.

2. Training

Personnel to be trained under this project include:

- nurse practioners,
- auxiliary midwives,

THAILAND
CHARACTERISTICS OF ACCELERATED FAMILY PLANNING AND HEALTH PROVINCES
(Population Figures as of September 1975)

Region	Province	Total Population	Rural Population/1	No. of Districts (A)	No. of Sub-Districts (B)	Total of (A and B)	No. of Tambols	No. of Tambols in Provincial Capital Dist./2	No. of Villages	No. of Villages in Provincial Capital Dist./2	No. of Health Facilities
North	Phichit	395,788	457,047	6	1	7	78	(13)	263	(13?)	99
	Petchabun	652,143	527,313	7	1	8	76	(10)	319	(13?)	119
	Nakhon Sawan	965,790	733,316	12	-	12	109	(10)	1,029	(15?)	187
	Pitsanulok	655,218	438,631	8	1	9	75	(12)	684	(13?)	141
	Kamphaeng Phet	497,849	369,747	4	1	5	44	(10)	420	(10+)	93
	Lamphun	330,321	199,727	3	-	3	48	(13)	243	(13?)	78
	Sukothai	497,824	308,259	8	1	9	70	(9)	304	(34)	131
	Sub-Total	(4,231,115)	(3,013,040)	(50)	(5)	(55)	(467)	(104)	(3,834)	(448)	(859)
Northeast	Buri Ram	1,030,152	855,026	10	1	11	93	(15)	1,376	(246)	168
	Si Sa Ket	957,272	804,108	9	1	10	127	(24)	1,395	(220)	215
	Surin	957,337	737,703	9	2	11	101	(19)	1,340	(242)	187
	Naka Yarothon	752,581	574,409	8	1	9	88	(17)	1,208	(184)	169
	Roi Et	938,656	820,584	11	2	13	128	(19)	1,561	(259)	208
	Ubon Thani	1,702,244	1,028,778	14	5	19	189	(24)	1,589	(163)	237
	Sub-Total	6,338,236	5,290,498	(68)	(14)	(82)	(737)	(117)	(9,234)	(1,449)	(1,368)
Central	Nakorn Phathom	387,989	335,148	6	-	6	93	(25)	373	(155)	115
	Saphan Buri	703,443	548,657	8	1	9	59	(19)	685	(97)	130
	Prachin Buri	553,271	470,297	9	2	11	63	(13)	802	(127)	125
	Kanchanaburi	425,249	323,295	10	-	10	78	(13)	471	(72)	121
	Sub-Total	(2,169,952)	(1,677,397)	(33)	(3)	(36)	(360)	(72)	(2,713)	(451)	(512)
South	Songkhla	740,553	595,526	10	-	10	114	(17)	891	(135)	201
	Nakhon Si Thammarat	1,193,488	965,822	15	1	16	133	(22)	1,012	(154)	243
	Sub-Total	(1,941,841)	(1,561,406)	(25)	(1)	(26)	(247)	(39)	(1,903)	(289)	(441)
	TOTAL	14,681,144	11,542,341	176	23	199	1,831	(332)	17,684	(3,099)	3,111

/1 Excluding population in provincial capitals.
/2 Shown as a figure.

Source: World Bank: Appraisal of a Population Project, August, 1977.

- health assistants,
- supervisory personnel,
- village volunteers, and
- health communicators

Included in this project are a variety of short term training activities which will upgrade the skills of new and existing MOPH staff and volunteers in the provision of primary health care basic services in rural areas.

The concept of short term training, as used in this paper, refers to training courses or seminars ranging in length from a week or less to several months. It encompasses in-service training for upgrading the skills of paramedicals and includes short basic or pre-service training for junior auxiliaries. It does not include basic training for those personnel which requires several years to complete.

This project concentrates heavily on financing training of health service providers and those personnel responsible for their support as follows:

a. Nurse Practitioners

(1) Need

The provision of health services to the Thai population, especially those living in the rural areas, is a grave problem faced by RTG. One of the most important obstacles to providing increased coverage to the rural population is the lack of appropriately trained personnel. There is a serious shortage of doctors, with most of them heavily concentrated in towns and cities. Approximately 70% of Thailand's doctors live in Bangkok.

Because of their heavy work-load, doctors in the rural areas cannot spend enough time to examine and diagnose patients properly. Thus, the quality of medical services provided to the rural population is far inferior to that provided to the population of major urban areas such as Bangkok.

Even with the projected rate of increase in the number of new doctors graduating from Thailand's medical schools (an increase from 385 to 500 doctors yearly), there will not be enough doctors to staff the rural health delivery system for some time. Also it is not realistic to imagine that high numbers of physicians will elect to serve in rural areas.

At the present time, approximately 130 district hospitals do not have a single doctor on their staff. To compensate for this shortage the MOPH has taken steps to delegate some of the functions commonly performed by doctors to a new category of personnel -- experienced nurses who will be trained and upgraded to become "nurse practitioners".

The new group will provide substantial medical care in the public health program at provincial and district hospitals. They will also supervise the overall public health and medical care activities of auxiliary staff in rural health facilities (e.g. health centers and midwifery centers). In the long run, the MOPH plans to staff all district hospitals with these nurse practitioners.

(2) Output

Institutional training in public health and medical care will be provided by the School of Public Health, Mahidol University. Nurses already trained in public health will receive a concentrated ten week course in medical care. Nurses with no background in public health will receive a 28 week course including both public health and medical care. Fourteen weeks of field training will be given to both groups by the MOPH. Two classes of 150 students each will start training in May of 1978, 1979 and 1980

These nurse practitioners will be taught the skills needed to:

- identify health problems,
- make differential diagnoses,
- handle emergencies and minor surgical procedures,
- treat minor illnesses,
- manage abnormal deliveries and perform episiotomies,
- carry out MCH and Family Planning services (including IUD insertions),
- participate in the administration of services in a district hospital or health center, and

- supervise district hospitals where no physicians are present.

To help ensure that sufficient numbers of nurse practitioners will be available to rural health services throughout the country, this project will support the training of 900 nurse practitioners -- 700 at the National level and 200 for AFPH provinces. Priority will be given to the preparation of nurse practitioners for the 20 AFPH provinces in district hospitals having no physicians.

(3) Input

This project will provide US$ 540,000 for field training of nurse practitioners. These costs include travel, per diem, training materials, and medical kits.

b. Auxiliary Midwives

(1) Need

The Government's Fourth National Economic and Social Development Plan emphasizes the provision of preventive, promotive, curative and rehabilitative health services in an integrated fashion for the whole country. The focus of the program is on expanded coverage and improved quality of service for the severely underserved rural areas. The number of health centers and midwifery clinics will be increased and their functions changed. Health services will be integrated so that medical care and treatment will be provided to the rural population in conjunction with preventive measures.

A practical nurse/midwife will be added to the staff of each new or upgraded health center, thus releasing the auxiliary midwives and junior sanitarians at these centers to undertake more field work. This will also enable the centers to remain open for longer hours.

A serious barrier to greater utilization of health centers and midwifery clinics has been the inability of the paramedicals staffing these facilities to offer the kinds of curative services sought by the public. The majority of the staff in rural areas are auxiliary midwives, practical nurse/midwives, sanitarians and practical nurses. They have been trained in sanitation, MCH/FP, environmental health, control of communicable diseases, and health education.

The MOPH has now increased the responsibilities of the auxiliary midwives to include the provision of medical care to the rural people. Essentially they will be providing limited curative services as physician extenders. Therefore, it is imperative that this category of health personnel have the necessary knowledge and ability to effectively deliver curative services and to perform their added duties within the scope of the responsibilities specified by the MOPH.

The new functions of the auxiliary midwives will include:

- minor surgical procedures and treatment of accidents,
- curative services for many common diseases,
- simple laboratory services (e.g. urinalyses to detect albumin and glucose; stool examinations for parasite ova; and blood tests to measure hemoglobin and to detect malaria parasites),
- identification of more serious conditions, emergency assistance and referral to a physician,
- collection, compilation and reporting of statistical data, and
- training, supervision and support of primary health care workers, village health volunteers and communicators.

(2) Output

A four month course in curative care has been developed to be given to all auxiliary midwives assigned to health and midwifery centers in the 20 MOPH provinces. Priority will be given to auxiliary midwives since they already play a more important role than junior sanitarians (the other major auxiliary worker staffing rural health facilities) in providing medical care.

In addition, auxiliary midwives have a crucial role in the delivery of family planning services. Improving their skill in medical care will increase public

acceptance of their advice and help in this and other areas of basic health. (As soon as auxiliary midwives are permitted to insert IUDs and provide injectables (DMPA), training will be initiated under the United Nations Fund for Population Activities (UNFPA) funded Family Planning grant. Priority will be given to midwives who have already completed the 4 months curative care training course.)

The training program in curative care will consist of one month's theoretical content and 3 months of practical training. Fourteen training institutions will participate in the program -- 3 MCH centers, 7 Nursing Colleges and 4 Practical Nursing Schools, each of which will provide the same curriculum.

The detailed curriculum for the auxiliary midwives' training is being prepared by the MOPH in consultation with the staff of the Lampang Project. This approach will make use of that project's experience in training and deploying auxiliaries with special training in medical care. Practical training will take place in provincial and district hospitals.

A two month curriculum (theoretical and practical) has been developed for the training of the personnel who will be responsible for the instruction of the auxiliary midwives. This training will include a review of basic medical and surgical knowledge and procedures and a study of teaching methodologies, as well as the preparation needed to provide the auxiliary midwives with the necessary skills for their new medical duties. 220 persons are scheduled to take this course.

In addition, approximately 500 physicians, nurses and nurse practitioners will be oriented to the expanded role of these auxiliary midwives during a series of one week seminars. These are personnel from the provincial and district hospitals and MCH centers in the 20 AFPH provinces who will be involved with the auxiliary midwives while they are doing their field training and, later, when they are assigned to their stations.

Over the 3 years of the project, 2,250 auxiliary midwives will undergo training in 90 groups of 25 trainees each.

AUXILIARY MIDWIFE TRAINING SCHEDULE

Training Facility	1978	1979	1980	1981*	Total
3 MCH Centers					
Trainees	75	225	225	75	600
Groups	(3)	(9)	(9)	(3)	(24)
7 Nursing Colleges					
Trainees	175	350	350	175	1050
Groups	(7)	(24)	(14)	(7)	(42)
4 Practical Nursing Schools					
Trainees	100	200	200	100	600
Groups	(4)	(8)	(8)	(4)	(24)
Total Trainees	350	775	775	350	2250
Total Groups	(14)	(31)	(31)	(14)	(90)

* Project length is three fiscal years, therefore the final groups of trainees will complete training in early 1981.

(3) Input

This project will provide US$ 2,297,000 for the training of auxiliary midwives. These costs include travel, per diem, training materials and medical kits for the trainees. Also included are the institutional costs for conducting the training programs and costs of training instructors.

c. Health Assistants

(1) Need

(a) Midwifery Centers

Currently each of the midwifery centers in the country are staffed with one person, an auxiliary midwife, who finds it difficult to simultaneously provide adequate clinical services at the center and extension services in the community. To ease the burden on midwives until their centers are upgraded to health centers (with one or two additional auxiliaries), health assistants will be temporarily assigned to the midwifery centers. The health assistants will be trained to perform routine tasks at the center and in the field. This will free the midwife for more technical tasks and for additional field responsibilities.

Specifically the duties of the health assistants will include:

- the preparation of clinical equipment, vaccination kits, and medical supplies;
- home visits to follow MCH patients and family planning acceptors;
- periodic contacts with village health volunteers to ensure that they are receiving adequate supplies of drugs and contraceptives;
- provision of first aid services when the auxiliary midwife is not available at the center;
- issuance of contraceptives to revisit clients;
- assistance with record keeping and routine reporting; and
- maintaining the midwifery center.

This class of junior paramedicals will be recruited locally. Recruitment will be from among unmarried women, aged 18-25, with a grade 10 education or higher, and who are otherwise eligible for basic training as auxiliary midwives or practical nurse/midwives. As they prove their

capability, these health assistants will eventually be upgraded to auxiliary midwives or practical nurse/midwives through additional training.

(b) MCH/Family Planning

Health assistants will also be prepared for nationwide deployment in provincial and district hospitals, provincial health offices where family planning services are offered, and MCH centers. The vast majority (about 90%) will be assigned to district hospitals (one each) and provincial hospitals (two each). The other 10% will be posted to provincial health offices with family planning clinics, and to the MCH centers.

These health assistants will:

- participate in the setting up and operation of Family Planning clinics;
- supply condoms and oral contraceptives;
- carry out face-to-face IEC activities in clinics and maternity wards;
- maintain family planning records and visit drop-outs.

Recruitment for the health assistants will be from among 20-40 year old women who are natives of the district with a grade 10 education or higher, and with a pre-existing interest in family planning and an ability to get along well with other people.

(2) Output

(a) Health Assistants for Midwifery Centers

A total of 750 health assistants for midwifery centers will be trained within the 20 AFPH provinces. This will provide a second person to staff each of the 735 midwifery centers that will be functioning by the end of the project period.

Training will last 6 weeks, of which 2 weeks will be devoted to classroom training at 2 of the MCH centers, and 4 weeks of practical training. Heavy emphasis

will be placed on MCH and family planning, with the following subjects also covered: nutrition, first aid, communicable disease control, minor treatments, use of basic drugs, record-keeping, health education, environmental sanitation and Thailand's rural health system.

Clinical training will take place in smaller groups or individually in various hospitals and rural health facilities.

Ten groups of 25 health assistants will be trained each year (i.e., 250) for 3 years.

(b) Health Assistants for MCH/FP

Health assistants for Maternal and Child Health/Family Planning will receive 2 weeks of classroom training and two weeks of practical training. Classroom training will be at the MCH center and will include training in:

- FP program and policies;
- population problems;
- human reproduction;
- specific contraceptive methods;
- history taking;
- setting up a clinic;
- sterilization of instruments;
- basic MCH;
- IEC (especially face-to-face communication);
- use of simple audio-visual aids;
- record-keeping procedures;
- referral system; and
- role of other health workers.

Practical training will be on a one-to-one basis, typically under the tutelage of a nurse in the hospital to which the health assistant will be assigned.

The project will support the training of 450 health assistants for MCH/Family Planning. Priority in training will be given to the 181 who will be assigned to the 20 AFPH provinces.

Categories	78	79	80	Total
Health Assistants Six Week Course (Primarily for Midwifery Centers)	100	450	200	750
Health Assistants Four Week Course (Primarily MCH/FP)	80	420	--	500
Total	180	920	200	1,250

(3) Input

This project will provide approximately US$ 243,000 for the training of health assistants. These costs include primarily travel, per diem and training material costs for the trainees, and travel and per diem for the instructors.

d. Child Nutrition Center Attendants

(1) Need

Child Nutrition Centers were started in 1968 as a means of reaching pre-school children in the rural areas. They are an adjunct to some of the rural health centers and provide day care services and supplementary feeding for children. Currently there are 620 centers in the country, 166 of them in the 20 AFPH provinces.

An average of 30 children are enrolled in each Child Nutrition Center. The 3 Ministries offering day care services (Public Health, Education, and Interior) have agreed to a standardized program of activities and in cooperation with the Ministry of Agriculture, the Centers provide supplemental protein foods for the children.

These Centers do not limit their activities to the feeding program but include such health related activities as immunizations, periodic physical examinations for the children, and the improvement of environmental factors which influence the children's health. An important aspect of the Child Nutrition Centers is the participation of the mothers in the normal functioning of the centers. Mothers take turns attending the centers, assisting in the preparation of meals, and helping in recreational activities. This first hand experience provides the mothers with practical information about foods and feeding practices. Normal daily activities include reading, group play and games as well as rest periods.

The auxiliary midwife responsible for the management of the center frequently arranges cooking demonstrations and education in nutrition, home food production and family planning for the mothers. Health center attendance appears to increase after a Child Nutrition Center has been added, probably because the Center not only meets a clear need, but also serves to link the community closer to the health center. These Child Nutrition Centers help increase community understanding and acceptance of rural health services by providing a focal point for community participation and education.

When a community decides to construct a Child Nutrition Center, the MOPH supplies the building materials and equipment and the community provides the labor for construction. This helps to ensure that these Centers are built only where they are wanted and needed. Local interest and participation in the future will be enlisted by village health volunteers and health communicators, with the help of the Tambon health staff.

When a community decides to build a center, one or two local women (depending upon the number of children expected) are selected to be attendants by the midwife and the village committee. These women are sent

to the provincial capital for two weeks training. They receive a modest stipend from the Government which is supplemented by fees collected from parents.

(2) Output

The project will train up to 180 child nutrition attendants. This training must be conducted on an ad hoc basis, since there will only be about 3 trainee per province per year.

(3) Input

The total costs for the training of nutrition center attendants will be US$ 9,000.

e. Health Volunteers and Health Communicators

(1) Need

The quality and supply of various categories of health manpower have generally failed to keep pace with the demand for services. At the present time, the great majority of Thailand's 46,000 villages have little or no access to modern health care. Even where government health facilities exist in some rural areas, only about 15% of the people who are sick use them. Most of the people buy medicine from the drug store and treat themselves, receive treatment from private clinics, or use traditional healers and Buddhist monks.

Besides the geographical distance from the government health facilities, another reason for under-utilization of these services is the perceived social distance between the government health worker and the rural villager. This prevents the patient and the physician or health worker from relating in a constructive manner. Consequently, the health professional is likely to have inadequate information both for diagnosis and treatment and the patient is limited in the care he/she can receive and utilize. In addition, because of these communication problems between government officials and the villagers the diffusion of public health information is quite restricted.

One of the strategies devised by the Fourth Five-Year Plan to counter this communication problem is a reorientation of service delivery away from physicians

and nurses toward the use of primary health care workers such as village health volunteers and communicators.

Over the past few years, a variety of health projects in Thailand have made use of different kinds of volunteers. Experience in these projects has shown that in a relatively short period of time, the volunteers became known and accepted as a source of health advice or services. For instance, after the first year of the Lampang Project, nearly 70% of the people in the project area were familiar with the volunteers, and about 55% of these had received advice from the communicators. Nearly all of these persons had followed this advice or intended to do so. About 30% of those who were familiar with the volunteers had turned to them for help during illnesses.

Because of experiences such as these, the RTG decided to launch a nationwide Primary Health Care Program based upon a corps of health volunteers and health communicators at the village level. This cadre of workers will provide essential health services and will also encourage public participation or self-help community services through village community organizations. Primary health care will thus be a health system developed and executed by the rural people with the support of the Government's organized health infrastructure.

The MOPH Health Training Division has been assigned special responsibility for developing the training of these primary health care workers. The training scheme consists of several stages. The first involves:

- training of the trainers in the essentials of the program, with considerable emphasis on training techniques;
- the establishment of new programs in the provincial and district hospitals and health centers throughout the country to prepare for the training of village health volunteers and health communicators; and
- the revision of curricula for nurses, midwives and sanitarians to include training in teaching medical care.

The second phase is the training of the staff of tambon health facilities - the auxiliary midwives and the junior sanitarians - for their role as trainers and technical supervisors of the village health volunteers and village communicators in their tambon. In actual fact, however, it is proposed that all echelons of health service personnel will participate in the training, guidance and motivation of the village volunteers and communicators.

The program calls for each auxiliary midwife and each junior sanitarian to be responsible for organizing the village health volunteer/health communicator program in one village (muban) per year. This entails establishing a special village committee or working with an existing committee. Primary health care will strongly rely on existing organizations set up in the villages. Community resources will be used to approach and solve health problems of the villagers, mainly through the network of village health volunteers and health communicators. Traditional practices and medicines will be included when relevant, and the Buddhist temple (Wat) and the monks will be involved also.

Communicators will be identified and recruited through socio-metric procedures** and interviews in the village by health center or midwifery staff. Existing traditional health care providers will be eligible and may very likely form the nucleus for these primary health care providers.*

When the health communicators have agreed to serve, the village health committee will select a village health volunteer, who may or may not be one of the communicators. The health communicators will work together with the village health volunteer as a team. They will also hold occasional meetings with the health center staff and/or the village committee.

The village health volunteers will receive 90 hours (6 hours x 15 days) of training, with arrangements to be worked out on an ad hoc basis between the volunteer and his/her trainer. After this initial training, on-going, relevant instruction will continue for 2 years.

* Traditional healers, primarily the traditional birth attendants, are trained through the USAID/T-supported Population Planning Project (t493-0283)

** A system devised to identify informal group leaders.

Responsibilities of the village health volunteer will include:

- Provision of minor health care, simple diagnosis of such illnesses as the common cold, malaria and parasitic infections, and dispensing of government basic pharmaceutical products. The village health volunteers will initially be issued approximately US$ 25.00 worth of drugs. They will sell these to the villagers at a price fixed by the MOPH. This will allow the volunteer a slight profit and will maintain a revolving fund for re-ordering of supplies.

- Supplying condoms, and oral contraceptives to women who have been screened for contraindications by qualified paramedicals.

- Working closely with local health center staff to organize local IEC events.

- Basic health education including MCH, FP, nutrition, communicable diseases, use of family planning and other health services.

- Assisting in vector control, especially the malaria vector, and prevention of endemic diseases (e.g. hookworm).

- Referring patients with more serious health problems to the nearest appropriate health facility.

- Serving as a member of the group of 10 health communicators in his/her village; and

- Acting as the liaison between government officials and the people.

The village health communicators will initially receive 30 hours (6 hours x 5 days) of instruction. This instruction will be an abbreviated version of the training given to the village health volunteer. Subsequently, the VSC will also continue to receive on the job training.

The village health communicator's role will be almost entirely in the IEC area. They will informally advise their neighbors and relatives about MCH, FP, Nutrition, important communicable diseases, sanitation, and other basic health topics. They will promote participation in local IEC events such as film showings, and in mass immunization programs. The village health communicators also encourage people to make use of the health services available in their area, and will work in close collaboration with the village health volunteers.

(2) Output

The RTG's ultimate aim is to have one village health volunteer and 10 health communicators available in each village that has no health or midwifery center. With an average of 9-10 villages (mubans) per tambon, each tambon could eventually have about 8 village health volunteers and 80 health communicators.

The national scheme calls for about half of the volunteers to be recruited and trained by the end of the five-year plan period in 1981. In the 20 AFPH provinces, however, recruitment will be accelerated. Thus, by the end of the project period, over half of the villages without health or midwifery centers will be covered, (i.e., there will be about 7,900 village health volunteers and 79,000 health communicators in the 20 AFPH provinces).

(3) Input

This project will provide US$1,130,000 for the training of sub-district staff, village health volunteers and communicators. These costs include primarily costs for training materials and equipment. Each trainee will be given a manual and a first aid kit.

The phasing of training for these personnel is as follows:

Category	1978	1979	1980	Total
Village Volunteers	1992	2900	3000	7892
Communicators	20655	29000	30000	79655
Total	22,157	31,900	33,000	87,547

f. Supervisory and Management Personnel

(1) Need

As discussed in previous sections, the RTG/MOPH will be implementing its Primary Health Care Program in twenty selected provinces. A key element of the PHCP is the use of village volunteers and communicators. Although the proposed project is conceptually uncomplicated, the implementation aspects of this project present management and logistical problems of enormous magnitude. Indeed, the success (or failure) of this project, will be due to a large degree on the management and supervisory skills of MOPH staff, particularly at the provincial, district and sub-district level.

Most of the responsibility for implementing this new project will be placed upon the auxiliary midwife and sanitarian at the sub-district (tambon) health center. These persons will be supervised by the district health facility staff, either a senior sanitarian, a nurse or midwife. The district staff will be supervised by the provincial health office staff of senior sanitarians, nurses and midwives. The overall management structure represents a typical organizational pyramid.

Because of the increased supervisory responsibilities at the district level, a new post of Deputy District Health Officer has been created. This person will be an experienced junior sanitarian or auxiliary midwife who will be promoted, most likely from one of the sub-district health centers in the 20 AFPH project provinces. This person will assume major responsibilities for management aspects of the health volunteer/communicator program in each district.

(2) Output

The RTG/MOPH has recognized the importance of the management aspects of this project and has developed several training programs to upgrade the management and supervisory skills of the provincial and district level health staff. More than 700 provincial and district health supervisory staff in the 20 project provinces will be given management training in courses which range from five days to four weeks in length.

The following table indicates which provincial and district level staff will receive management training:

	Title	Number	Course Duration	Training Frequency
1.	Provincial Chief Medical Officer	20	7 days	2 **
2.	Director Technical Health Services	20	7 days	2 **
3.	Director Provincial Hospital ..	23	7 days	1
4.	Chief Planning Section	20	5 days	2 **
5.	Chief Training, Education, Health Promotion.....	40	5 days	1
6.	Director District Hospital.....	103	5 days	1
7.	District Health Officer.....	199	5 days	1
8.	Assistant District Health Officer 1/*.....	199	4 weeks	1
9.	Chief, Promotion Section, District Hospital	103	7 days	1
10.	Provincial Supervisors *	20	4 weeks	1

1/ Newly created position

* Trained by Health Training Division. All others will be trained by the Health Planning Division.

** These persons will receive training twice, once during the first project year and once during the second.

Training plans, including curricula, have already been developed in anticipation of this project. The overall objective of these management courses will be to ensure that key senior and middle level health and hospital administrators develop the skills necessary to manage this project and other aspects of the provincial health care program. Training topic areas will include health planning, public health administration and hospital management within the context of the newly formed primary health care program. Much of this training will be conducted at the four regional health training centers.

(3) Input

This project will provide US$ 90,000 to finance the training costs for this program component. Costs include trainee travel and per diem, costs for training materials and institutional costs.

3. Research and Evaluation

(a) Need

The RTG's Fourth Five Year Plan has identified improved health planning and management as one of the nation's five goals in the health sector. One aspect of this Rural Primary Health Care Expansion Project will seek to support the MOPH's efforts in this area.

In 1970, WHO initiated a Planning, Management and Information System (PMIS) Project. The purpose of this effort was to improve the MOPH's capability in national health planning and administration. Expenditures on this project, which ended in 1976, were over US$ 520,000.

As a result of the WHO PMIS project, a number of important accomplishments were achieved, including:

- an increased awareness within the RTG's MOPH of the need for, and usefulness of, sound program planning and management.
- the development of annual operating plans for each of the country's 72 provinces.
- the establishment of a Central Information Center and approximately 20 Provincial Information Centers.* Information Centers for the remaining provinces are being established.
- the development of two information subsystems which are currently being field tested.
- the development of an analytic and evaluation capability within the MOPH to improve implementation of a national health planning process.

* Not all are congruent with the 20 AFPH provinces.

At present, the PMIS system is under the direction of the Central Information Center of the Planning and Evaluation Unit in the MOPH. There are, however, several units within the MOPH which also have responsibility for planning, management and monitoring of health care services and delivery. For example, the Family Health Division supervises and evaluates the delivery of FP services throughout the country. Also, the Malaria Eradication Division of the Department of Communicable Disease Control is involved in planning and implementation activities in malaria control.

The RTG recognizes that its emphasis on the development of an effective primary health care program, and its efforts to improve the delivery of health services to rural areas will require continuous planning, monitoring and evaluation. It is for this reason that the RTG has included improved health research and evaluation as elements of its goal of improved health planning and management.

The responsibility for supervising and coordinating the planning, research, and evaluation efforts within the MOPH will be in the Health Planning Division. This is part of the Office of the Deputy-Under-Secretary of State for Planning and Evaluation. This Division, established in 1973, will have responsibility for:

- coordinating all planning, research and evaluation activities within the MOPH
- planning, designing and implementing operational and evaluation studies
- development of management training programs to ensure that study results and operational improvements are transmitted to the proper supervisory health personnel.

Thus, the RTG clearly understands the need for dynamic planning and evaluation within its health delivery system. It is entrusting the implementation of these efforts to a unit within the MOPH that has already been established and is functioning. The fact that the RTG is willing to use loan funds for this activity further underscores its interest and commitment.

Beyond this, the RTG appreciates the special needs of the AFPH project for research and evaluation. It will, therefore, set up a special unit within the HPD that will be responsible for coordinating all research and evaluation efforts of other systems (e.g. PMIS, NFPP) with those of the AFPH project.

In this context, the MOPH will undertake a number of surveys and studies that will evaluate the progress, performance, acceptance and effectiveness of its health programs. Particular emphasis will be given to the AFPH project and the delivery of services to the rural poor. As a result of these studies and surveys, the MOPH will be able to make necessary adjustment to its project efforts -- to correct inadequacies and improve deficiencies.

Given this concern that there be strong coordination of planning, management and evaluation activities throughout the MOPH, particularly as they relate to the RTG/AFPH project, this project will support the strengthening of the evaluation and research unit within the HPD that will be monitoring the RTG/AFPH project.

(b) Outputs

As noted above, the research and evaluation unit within the Health Planning Division (HPD) will concentrate its efforts in two key areas:

- coordination of all planning, research and evaluation activities within the MOPH, as they relate to the AFPH project.

- operational and evaluation studies.

The HPD will strengthen its coordinating capability with existing data systems (NFPP, PMIS), at the same time that it will seek to improve planning and monitoring activities for the 20 AFPH provinces.

At present, the HPD has identified three studies related to the AFPH project which it plans to implement in 1978:

- An operational assessment of health facilities and manpower in the 20 provinces involved in the AFPH project.

- An evaluation of the training of the village health volunteers and the village health communicators. This study will seek to assess such factors as the relevance of training materials, the adequacy of training methods, and the optimum length of the training period.

- An evaluation of the training of trainers for the village health volunteers and health communicators.

In 1979, the MOPH is planning to implement the following:

- A repeat of the previous year's operational assessment of health facilities and manpower

- The initiation of patient survey studies based on household interviews

- Operational studies of the performance of nurse practitioners, auxiliary midwives and health assistants

- Evaluation studies of village health volunteers and village health communicators

For 1980, the HPD will repeat the operational study of health facilities and manpower. At present, plans for the remainder of the research and evaluation program for 1980 have not been completed.

(c) Inputs

This project will provide US$ 846,000 to support the planning, research and evaluation activities of the Rural Primary Health Care Expansion Project. These funds will assist the MOPH to strengthen the coordinating and monitoring functions of the evaluation and research unit within the HPD particularly as it relates to the RTG/AFPH project. Project assistance will include:

- One full time health care planning research and evaluation specialist over a three year period. This professional will be assigned to the MOPH Division of Health Planning and will assist in the planning, design and implementation of training, operational research, and evaluation studies of the Primary Health Care Program.

- One full time research assistant and a local hire secretary, who will work with the full time health care planning, research and evaluation specialist in the HPD.

- Short term technical consultants with expertise in special areas of planning and evaluation (e.g. health manpower evaluation, household survey techniques, facilities utilization survey methods).

- Equipment and supplies for operational and evaluation studies in the 20 AFPH provinces.

Rural Primary Health Care

Project Financial Plan
($millions)

As of _____, 1978

Project #493-0291

Project Inputs	AID Loan	RTG	Total
Technical Assistance			
a) Long-term Contract	240	-	240
b) Short-term Consultants	90	-	90
Training			
a) Nurse Practitioners *	540	-	540
b) Auxiliary Midwives *	2,297	-	2,297
c) Prov. & Dist. Supervisors	90	-	90
d) Health Assistants	243	-	243
e) VH Volunteers *	498	-	498
f) VH Communicators	632	-	632
g) CNC Attendants	9	-	9
Research & Evaluation	516	-	516
Salaries and Allowances	-	5,230	5,230
Contingency	50	-	50
Inflation	295	-	295
	5,500	5,230	10,730

* Includes Commodity Costs of $553,710 for Medical Kits (NP's 900 x $25; MW 2,250 x $175; VHV 7,900 x $17 40)

Joint RTG/USAID Evaluations

Together with the RTG, USAID will evaluate project effectiveness and efficiency. This is a key aspect of the overall evaluation strategy. It is consistant with the RTG's responsibility for designing and implementing improvements in its own health infrastructure.

The joint RTG/USAID evaluations will be conducted by a team composed of :

- RTG representatives from the MOPH and other related Ministries.
- USAID/T health staff
- USAID/W health staff
- U.S. non-government experts in rural health development.

It is expected that two such joint evaluations will be conducted. The first (interim evaluation) will take place by the 18th month of the project, and the second (final evaluation) upon the termination of the project.

The evaluation of project effectiveness and efficiency will be related to the specific goals and objectives of the project. In addition, certain evaluation indicators will be utilized. These indicators will be related to the two major elements of the programm -- training and research/evaluation.

Evaluation indicators will involve such factors as:

- appropriateness of new skills that are imparted to the health personnel
- acceptance of the health personnel by the community in which they work

- attitude of patients to the health personnel
- integration of the health personnel into the existing health infrastructure
- attitudes of the new health personnel to their profession, as well as analysis of retention/drop-out rates
- involvement of the health personnel, especially those assigned to the village level facilities, in health related promotive, educational and preventive activities
- ability of the RTG to provide logistical support to the newly trained health personnel
- ability of the RTG to expand its data system into the 20 AFPH provinces utilizing the newly trained personnel
- quality and quantity of research and evaluation studies performed by the Health Planning Division.

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